

brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

DENTAL BENEFITS ADDENDUM

**BRAND NEW DAY
HEALTH PLAN**

Enhanced Mandatory Option 2
CAC39

Administered by:



Table of Contents

| | |
|---|----|
| Introduction | 1 |
| Definitions | 2 |
| How to use this Plan - Choice of Participating Provider | 4 |
| Continuity of Care | 5 |
| Facility Accessibility | 5 |
| Benefits, Limitations and Exclusions | 5 |
| Copayments and Other Charges | 6 |
| Emergency Services | 6 |
| Specialist Services | 6 |
| Second Opinion | 7 |
| Claims for Reimbursement | 7 |
| Provider Compensation | 7 |
| Processing Policies | 8 |
| Coordination of Benefits | 8 |
| Grievance and Appeals Process | 9 |
| Renewal and Termination of Benefits | 9 |
| Cancellation of Enrollment | 9 |
| Schedule A - Description of Benefits and Copayments | 10 |
| Schedule B - Limitations and Exclusions of Benefits | 27 |

INTRODUCTION

We are pleased to welcome you to the dental plan for BRAND NEW DAY. Your plan is administered by Delta Dental of California (“Delta Dental”). Our goal is to provide you with high quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

This plan is available in the following counties: Alameda, Contra Costa, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Stanislaus, Tulare and Yolo.

Using This Evidence of Coverage

This Dental Benefit Addendum (“Plan”), which includes Attachment A, Schedule of Copayments and Attachment B, Services, Limitations and Exclusions, discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the Plan works and how to obtain dental care. Please read this booklet completely and carefully. Please read the Definitions section, which will explain any words that have special or technical meanings in this Plan.

The benefit explanations contained in this Plan booklet are subject to all provisions of the Contract on file with BRAND NEW DAY (“Contractholder”) and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Notice: *This Plan booklet is a summary of your dental plan, and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered Benefits, services or payments.*

Contact Us

For more information please visit www1.deltadentalins.com/brand-new-day-medicare or call Delta Dental’s Customer Service Center at 844-282-7638 (TTY 711). A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Participating Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access Delta Dental’s automated information line at 844-282-7638 (TTY 711) during regular business hours to obtain information about Member’s eligibility and Benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

Delta Dental
1130 Sanctuary Parkway
Alpharetta, GA 30009

DEFINITIONS

Terms when capitalized in this Plan booklet have defined meanings, given in the section below or throughout the booklet sections.

Appeal -- is something you do if you disagree with a decision to deny a request for dental care services or payment for services you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a service, you think you should be able to receive.

Benefits -- the dental services under this Plan to which you are entitled to receive.

Calendar Year -- the 12 months of the year from January 1st through December 31st.

Claim Form -- the standard form used to file a claim or request a Pre-Treatment Estimate.

Contract -- the Agreement between BRAND NEW DAY Plan and Delta Dental of California for the Provision of Dental Services.

Contractholder -- BRAND NEW DAY Plan.

Cost-sharing -- the amounts which may be charged to a Member as the Member's share of the cost for the provision of covered services. Cost sharing under this Plan consists of copayments listed in Attachment A.

Delta Dental Participating Provider (Participating Provider) -- means a person licensed to practice dentistry when and where performed who has entered into a contract with Delta Dental agreeing to participate in this Plan and provide covered services in general dentistry to Members.

Emergency Service -- means dental care furnished to a Member needed to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Member to result in either: (i) placing the Member's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

Effective Date -- the original date the Plan starts. This date is given on this booklet's cover and Attachment A.

Member -- a person with Medicare who is eligible to get covered services, who has enrolled in the Plan and whose enrollment has been confirmed by CMS.

Non Participating Provider -- a dentist who has not entered into an agreement with Delta Dental to be a Participating Provider under this Plan.

Plan -- this dental plan which describes the Benefits, limitations, exclusions, terms and conditions of coverage for Members enrolled in Contractholder's Medicare Advantage Plan.

Plan Year -- the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Pre-Treatment Estimate -- an estimation of the allowable Benefits under the Plan for the services proposed.

Procedure Code -- the Current Dental Terminology® (CDT) number assigned to a Single Procedure by the American Dental Association.

Reasonable means that a Member exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Participating Provider to obtain Emergency Services and, in the event the Participating Provider is not available, makes at least one attempt to contact Delta Dental for assistance before seeking care from another Participating Provider.

Single Procedure -- a dental procedure that is assigned a separate Procedure Code.

Specialist Services -- mean services performed by a licensed dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized in writing by Delta Dental.

Treatment in Progress -- means any single dental procedure, as defined by the Procedure Code that has been started while the Member was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Member continues to be eligible for Benefits under the Plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken.

How to use this Plan - Choice of Participating Provider

To receive Benefits under this Plan, you must select a Participating Provider from the directory of Participating Providers. If you fail to select a Participating Provider or the Participating Provider selected by you becomes unavailable, we will request you select another Participating Provider, or we will assign you to a Participating Provider. You may change your assigned Participating Provider by directing a request to the Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711). In order to ensure that your Participating Provider is notified, and our eligibility lists are correct, changes in Participating Providers must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a membership packet that tells you the effective date of your Plan and the address and telephone number of your Participating Provider. After the effective date in your membership packet, you may obtain dental services under the Plan. To make an appointment simply call your Participating Provider's facility and identify yourself as a Member through BRAND NEW DAY Plan. Inquiries regarding availability of appointments and accessibility of Participating Providers should be directed to the Customer Service department at 844-282-7638 (TTY users 711).

EACH MEMBER MUST GO TO HIS OR HER ASSIGNED PARTICIPATING PROVIDER TO OBTAIN COVERED SERVICES, EXCEPT EMERGENCY SERVICES OR SERVICES PROVIDED BY A SPECIALIST, WHICH MUST BE PREAUTHORIZED IN WRITING BY DELTA DENTAL. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PLAN.

If your assigned Participating Provider's agreement with Delta Dental terminates, that Participating Provider will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Continuity of Care

Existing Members:

You may have the right to have completion of care with your terminated Participating Provider for certain specified dental conditions. Please call Customer Service at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Participating Provider. We are not required to continue your care with that Participating Provider if you are not eligible for coverage under the Plan or if we cannot reach agreement with your terminated Participating Provider on the terms regarding your care.

New Members:

You may have the right to the qualified benefit of completion of care with a Non Participating Provider for certain specified dental conditions. Please call the Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Non Participating Provider. We are not required to continue your care with that dentist if you are not eligible under the Plan or if we cannot reach agreement with your dentist on the terms regarding your care.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711).

Benefits, Limitations and Exclusions

This Plan provides the Benefits described in Attachment A, Description of Benefits and Copayments subject to the limitations and exclusions described in Attachment B. The services are performed as deemed appropriate by your attending Participating Provider. A Participating Provider may provide services either personally or through associated dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the Attachment A, Description of Benefits and Copayments directly to the Participating Provider or Specialist who provides treatment. Charges for broken appointments (unless notice is received by the dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the Description of Benefits and Copayments.

Emergency Services

If Emergency Services are needed, you should contact your Participating Provider whenever possible. If you are a new Member needing Emergency Services, but do not have an assigned Participating Provider yet, contact Delta Dental's Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) for help in locating a Participating Provider. Benefits for Emergency Services by a Non Participating Provider are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

- 1) have made a Reasonable attempt to contact the Participating Provider and the Participating Provider is unavailable or you cannot be seen within 24 hours of making contact; or
- 2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is Reasonable for you to access Emergency Services without prior contact with Delta Dental; or
- 3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Participating Provider to receive Emergency Services.

Benefits for Emergency Services not provided by the Participating Provider are limited to a maximum of \$100.00 per emergency less the applicable Copayment. If the maximum is exceeded, or the above conditions are not met, you are responsible for any charges for services by a dentist other than your Participating Provider.

Specialist Services

Specialist Services must be referred by the assigned Participating Provider and preauthorized in writing by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments.

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Participating Provider. Delta Dental may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) or write to Delta Dental.

Second opinions will be provided at another Participating Provider's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by a Non Participating Provider if an appropriately qualified Participating Provider is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file an Appeal with BRAND NEW DAY. Please refer to the section of this booklet titled "Grievance and Appeals Process" below for an explanation of how to file an Appeal.

Claims for Reimbursement

Claims for Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is Claims Department, P. O. Box 1810, Alpharetta, GA 30023.

Provider Compensation

A Participating Provider is compensated by Delta Dental through monthly capitation (an amount based on the number of Members assigned to the Participating Provider), and by Members through required Cost Sharing for treatment received. A Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by the Member. In no event does Delta Dental pay a Participating Provider or a Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

In the event we fail to pay a Participating Provider, you will not be liable to that Participating Provider for any sums owed by us. The Participating Provider's contract with Delta Dental contains a provision prohibiting the Participating Provider from charging a Member for any sums owed by Delta Dental. Except for the provisions in Emergency Services, if you have not received Preauthorization for treatment from a Non Participating Provider or Specialist, and we fail to pay that dentist you may be liable to that dentist for the cost of services.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number listed in this booklet.

Processing Policies

The dental care guidelines for the Plan explain to Participating Providers what services are covered under the dental Contract. Participating Providers will use their professional judgment to determine which services are appropriate for the Member. Services performed by the Participating Provider that fall under the scope of Benefits of the dental Plan are provided subject to any Copayments. If a Participating Provider believes that a Member should obtain treatment from a Specialist, the Participating Provider contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Specialist. A Member may contact Delta Dental's Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) for information regarding the dental care guidelines for the Plan.

Coordination of Benefits

This Plan provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits Plan if the other policy or Plan covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Plan by Specialists or Non Participating Providers are coordinated with such other group dental insurance policy or any group dental benefits Plan. The determination of which policy or Plan is primary shall be governed by the rules stated in the Contract.

If this plan is secondary, it will pay the lesser of:

- the amount that it would have paid in the absence of any other dental benefit coverage, or
- the enrollee's total out-of-pocket cost payable under the primary dental benefit plan.

A Member must provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Member that

is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Plan. Delta Dental will have the right to recover from a dentist, Member, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Grievance and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Participating Providers to the courtesy extended you by our telephone representatives. If you have any question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Participating Provider, you have the right to file a grievance or appeal with BRAND NEW DAY. See your BRAND NEW DAY Evidence of Coverage Booklet for information on the grievance process or contact BRAND NEW DAY at the 866-255-4795 on your BRAND NEW DAY Plan Member ID card.

Renewal and Termination of Benefits

This Plan renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and BRAND NEW DAY does not accept the change. All Benefits terminate for any Member as of the date that this Plan is terminated, such person ceases to be eligible under the terms of this Plan, or such person's enrollment is cancelled under the terms of this Plan. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of Single Procedures commenced while this Plan was in effect.

Cancellation of Enrollment

To be eligible for Benefits under this Plan, you must be enrolled under one of the various Medicare Advantage health plans or products offered by BRAND NEW DAY. If you lose your eligibility or you terminate your enrollment under your BRAND NEW DAY plan you are not eligible to receive Benefits under this Plan. See your BRAND NEW DAY Evidence of Coverage Booklet for enrollment terms and conditions.

SCHEDULE A

Description of Benefits and Copayments

DHMO - CAC39 - Enhanced Mandatory Option 2

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to Schedule B for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DHMO program and is not to be interpreted as Current Dental Terminology (“CDT”), CDT-2023 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association (“ADA”). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

| CODE | DESCRIPTION | ENROLLEE PAYS |
|-------------|--|---------------|
| D0100-D0999 | I. DIAGNOSTIC | |
| D0120 | Periodic oral evaluation - established patient | No Cost |
| D0140 | Limited oral evaluation - problem focused | No Cost |
| D0150 | Comprehensive oral evaluation - new or established patient | No Cost |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report - <i>1 per 6 month period</i> | No Cost |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post operative visit) - <i>1 per 6 month period</i> | No Cost |
| D0171 | Re-evaluation - post-operative office visit | No Cost |
| D0180 | Comprehensive periodontal evaluation - new or established patient - <i>1 per 6 month period</i> | No Cost |
| D0190 | Screening of a patient | No Cost |
| D0191 | Assessment of a patient | No Cost |
| D0210 | Intraoral - comprehensive series of radiographic images - <i>limited to 1 series every 2 years</i> | No Cost |
| D0220 | Intraoral - periapical first radiographic image | No Cost |
| D0230 | Intraoral - periapical each additional radiographic image | No Cost |
| D0240 | Intraoral - occlusal radiographic image | No Cost |
| D0250 | Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector | No Cost |
| D0251 | Extraoral posterior dental radiographic image | No Cost |
| D0270 | Bitewing - single radiographic image | No Cost |

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| D0272 | Bitewings two radiographic images - <i>limited to 1 every 12 months, per provider</i> | No Cost |
| D0273 | Bitewings three radiographic images - <i>limited to 1 every 12 months, per provider</i> | No Cost |
| D0274 | Bitewings - four radiographic images - <i>limited to 2 series per year, per provider</i> | No Cost |
| D0277 | Vertical bitewings - 7 to 8 radiographic images | No Cost |
| D0330 | Panoramic radiographic image | No Cost |
| D0340 | 2D cephalometric radiographic image - acquisition, measurement and analysis | No Cost |
| D0460 | Pulp vitality tests | No Cost |
| D0470 | Diagnostic casts | No Cost |
| D0601 | Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i> | No Cost |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i> | No Cost |
| D0603 | Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i> | No Cost |
| D0999 | Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i> | No Cost |
| | | |
| D1000-D1999 | II. PREVENTIVE | |
| D1110 | Prophylaxis cleaning - adult - <i>Limited to 2 per year</i> | No Cost |
| D1206 | Topical application of fluoride varnish | No Cost |
| D1208 | Topical application of fluoride - excluding varnish | No Cost |
| D1310 | Nutritional counseling for control of dental disease | No Cost |
| D1320 | Tobacco counseling for the control and prevention of oral disease | No Cost |
| D1330 | Oral hygiene instructions | No Cost |
| D1352 | Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to first and second permanent molars</i> | \$10.00 |
| D1353 | Sealant repair - per tooth - <i>limited to first and second permanent molars</i> | \$10.00 |
| D1354 | Application of caries arresting medicament - per tooth - 1 per 6 month period | \$12.00 |
| D1510 | Space maintainer - fixed - unilateral - per quadrant | \$75.00 |
| D1516 | Space maintainer - fixed - bilateral, maxillary | \$95.00 |
| D1517 | Space maintainer - fixed - bilateral, mandibular | \$95.00 |

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| D1520 | Space maintainer - removable - unilateral - per quadrant | \$75.00 |
| D1526 | Space maintainer - removable - bilateral, maxillary | \$95.00 |
| D1527 | Space maintainer - removable - bilateral, mandibular | \$95.00 |
| D1551 | Re-cement or re-bond bilateral space maintainer - maxillary | \$20.00 |
| D1552 | Re-cement or re-bond bilateral space maintainer - mandibular | \$20.00 |
| D1553 | Re-cement or re-bond unilateral space maintainer - per quadrant | \$20.00 |
| D1556 | Removal of fixed unilateral space maintainer - per quadrant | No Cost |
| D1557 | Removal of fixed bilateral space maintainer - maxillary | No Cost |
| D1558 | Removal of fixed bilateral space maintainer - mandibular | No Cost |

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

- Fillings are limited to one amalgam, resin composite filling per surface per tooth, every 2 calendar years.

- Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #3 for additional information.

- Base metal is the benefit. If a crown, pontic, inlay, onlay or indirectly fabricated post and core is made of noble or high noble metal, an additional fee up to \$250.00 per tooth will be charged for the upgrade. This charge also applies to a titanium crown.

- Porcelain and other tooth-colored materials (i.e. resin) on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$250.00.

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| D2140 | Amalgam - one surface, primary or permanent | \$40.00 |
| D2150 | Amalgam - two surfaces, primary or permanent | \$50.00 |
| D2160 | Amalgam - three surfaces, primary or permanent | \$60.00 |
| D2161 | Amalgam - four or more surfaces, primary or permanent | \$70.00 |
| D2330 | Resin-based composite - one surface, anterior | \$60.00 |
| D2331 | Resin-based composite - two surfaces, anterior | \$70.00 |
| D2332 | Resin-based composite - three surfaces, anterior | \$80.00 |
| D2335 | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | \$90.00 |

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| D2390 | Resin-based composite crown, anterior | \$98.00 |
| D2391 | Resin-based composite - one surface, posterior | \$90.00 |
| D2392 | Resin-based composite - two surfaces, posterior | \$100.00 |
| D2393 | Resin-based composite - three surfaces, posterior | \$110.00 |
| D2394 | Resin-based composite - four or more surfaces, posterior | \$120.00 |
| D2510 | Inlay - metallic - one surface | \$300.00 |
| D2520 | Inlay - metallic - two surfaces | \$300.00 |
| D2530 | Inlay - metallic - three or more surfaces | \$300.00 |
| D2542 | Onlay - metallic - two surfaces | \$400.00 |
| D2543 | Onlay - metallic - three surfaces | \$400.00 |
| D2544 | Onlay - metallic - four or more surfaces | \$400.00 |
| D2610 | Inlay - porcelain/ceramic - one surface | \$400.00 |
| D2620 | Inlay - porcelain/ceramic - two surfaces | \$400.00 |
| D2630 | Inlay - porcelain/ceramic - three or more surfaces | \$400.00 |
| D2642 | Onlay - porcelain/ceramic - two surfaces | \$400.00 |
| D2643 | Onlay - porcelain/ceramic - three surfaces | \$400.00 |
| D2644 | Onlay - porcelain/ceramic - four or more surfaces | \$400.00 |
| D2650 | Inlay - resin-based composite - one surface | \$400.00 |
| D2651 | Inlay - resin-based composite - two surfaces | \$400.00 |
| D2652 | Inlay - resin-based composite - three or more surfaces | \$400.00 |
| D2662 | Onlay - resin-based composite - two surfaces | \$400.00 |
| D2663 | Onlay - resin-based composite - three surfaces | \$400.00 |
| D2664 | Onlay - resin-based composite - four or more surfaces | \$400.00 |
| D2710 | Crown - resin-based composite (indirect) - limited to permanent anterior teeth | \$200.00 |
| D2712 | Crown - 3/4 resin-based composite (indirect) | \$200.00 |
| D2720 | Crown - resin with high noble metal | \$200.00 |
| D2721 | Crown - resin with predominantly base metal | \$200.00 |
| D2722 | Crown - resin with noble metal | \$200.00 |
| D2740 | Crown - porcelain/ceramic | \$400.00 |
| D2750 | Crown - porcelain fused to high noble metal | \$350.00 |
| D2751 | Crown - porcelain fused to predominantly base metal | \$275.00 |
| D2752 | Crown - porcelain fused to noble metal | \$400.00 |

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| D2780 | Crown - 3/4 cast high noble metal | \$400.00 |
| D2781 | Crown - 3/4 cast predominantly base metal | \$400.00 |
| D2782 | Crown - 3/4 cast noble metal | \$400.00 |
| D2783 | Crown - 3/4 porcelain/ceramic | \$400.00 |
| D2790 | Crown - full cast high noble metal | \$400.00 |
| D2791 | Crown - full cast predominantly base metal | \$400.00 |
| D2792 | Crown - full cast noble metal | \$400.00 |
| D2794 | Crown - titanium and titanium alloys | \$400.00 |
| D2799 | Interim crown - further treatment or completion of diagnosis necessary prior to final impression | \$25.00 |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | \$50.00 |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | \$50.00 |
| D2920 | Re-cement or re-bond crown | \$50.00 |
| D2921 | Reattachment of tooth fragment, incisal edge or cusp (anterior) | \$98.00 |
| D2929 | Prefabricated porcelain/ceramic crown - primary tooth | \$190.00 |
| D2930 | Prefabricated stainless steel crown - primary tooth | \$150.00 |
| D2931 | Prefabricated stainless steel crown - permanent tooth - <i>1 in 36 months</i> | \$170.00 |
| D2932 | Prefabricated resin crown - anterior primary tooth - <i>1 in 36 months</i> | \$170.00 |
| D2933 | Prefabricated stainless steel crown with resin window - <i>1 in 36 months</i> | \$190.00 |
| D2940 | Protective restoration | \$40.00 |
| D2941 | Interim therapeutic restoration - primary dentition | \$40.00 |
| D2949 | Restorative foundation for an indirect restoration | \$150.00 |
| D2950 | Core buildup, including any pins when required | \$150.00 |
| D2951 | Pin retention - per tooth, in addition to restoration | \$50.00 |
| D2952 | Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> | \$220.00 |
| D2953 | Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> | \$110.00 |
| D2954 | Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i> | \$160.00 |

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| D2957 | Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i> | \$90.00 |
| D2971 | Additional procedures to customize a crown to fit under an existing partial denture framework. | \$50.00 |
| D2975 | Coping | \$110.00 |
| D2980 | Crown repair necessitated by restorative material failure | \$25.00 |
| D2981 | Inlay repair necessitated by restorative material failure | \$25.00 |
| D2982 | Onlay repair necessitated by restorative material failure | \$25.00 |
| D2983 | Veneer repair necessitated by restorative material failure | \$25.00 |
| D2990 | Resin infiltration of incipient smooth surface lesions | \$65.00 |

D3000-D3999 IV. ENDODONTICS

- Endodontic services are limited to 1 per tooth, per lifetime (i.e. root canal).

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| D3110 | Pulp cap - direct (excluding final restoration) | \$25.00 |
| D3120 | Pulp cap - indirect (excluding final restoration) | \$40.00 |
| D3220 | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | \$150.00 |
| D3221 | Pulpal debridement, primary and permanent teeth | \$150.00 |
| D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | \$180.00 |
| D3240 | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | \$300.00 |
| D3310 | <i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) | \$380.00 |
| D3320 | <i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration) | \$490.00 |
| D3330 | <i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration) | \$620.00 |
| D3331 | Treatment of root canal obstruction; non-surgical access | \$180.00 |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | \$200.00 |
| D3333 | Internal root repair of perforation defects | \$160.00 |
| D3346 | Retreatment of previous root canal therapy - anterior | \$500.00 |
| D3347 | Retreatment of previous root canal therapy - premolar | \$620.00 |
| D3348 | Retreatment of previous root canal therapy - molar | \$720.00 |

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| D3351 | Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) | \$190.00 |
| D3352 | Apexification/recalcification - interim medication replacement | \$130.00 |
| D3353 | Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | \$150.00 |
| D3410 | Apicoectomy - anterior | \$420.00 |
| D3421 | Apicoectomy - premolar (first root) | \$460.00 |
| D3425 | Apicoectomy - molar (first root) | \$480.00 |
| D3426 | Apicoectomy (each additional root) | \$150.00 |
| D3427 | Periradicular surgery without apicoectomy | \$360.00 |
| D3430 | Retrograde filling - per root | \$130.00 |
| D3450 | Root amputation - per root | \$220.00 |
| D3920 | Hemisection (including any root removal), not including root canal therapy | \$190.00 |
| D3921 | Decoronation or submergence of an erupted tooth | \$80.00 |

D4000-D4999 V. PERIODONTICS

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

- No more than 2 quadrants of periodontal scaling and root planing per appointment/per day are allowable.

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| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant in 36 months | \$220.00 |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant - once per quadrant in 36 months | \$150.00 |
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth - once per quadrant in 36 months | \$150.00 |
| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | \$540.00 |
| D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | \$540.00 |
| D4245 | Apically positioned flap | \$425.00 |
| D4249 | Clinical crown lengthening - hard tissue | \$500.00 |

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| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant - <i>once per quadrant in 36 months</i> | \$780.00 |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant - <i>once per quadrant in 36 months</i> | \$550.00 |
| D4263 | Bone replacement graft - retained natural tooth - first site in quadrant | \$360.00 |
| D4264 | Bone replacement graft - retained natural tooth - each additional site in quadrant | \$300.00 |
| D4270 | Pedicle soft tissue graft procedure | \$400.00 |
| D4274 | Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) | \$320.00 |
| D4277 | Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft | \$480.00 |
| D4278 | Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site | \$480.00 |
| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 1 per quadrant per year</i> | \$60.00 |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 1 per quadrant per year</i> | \$35.00 |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110 or D4346 per 6 month period</i> | \$15.00 |
| D4355 | Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i> | \$40.00 |
| D4381 | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - <i>included as part of other covered periodontal procedures</i> | \$40.00 |
| D4910 | Periodontal maintenance - limited to 1 treatment per 6 month period | \$40.00 |
| D4921 | Gingival irrigation with a medicinal agent - per quadrant | No Cost |

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes other delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 2 per denture per calendar year.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

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| D5110 | Complete denture - maxillary | \$450.00 |
| D5120 | Complete denture - mandibular | \$450.00 |
| D5130 | Immediate denture - maxillary | \$600.00 |
| D5140 | Immediate denture - mandibular | \$600.00 |
| D5211 | Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) | \$500.00 |
| D5212 | Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) | \$500.00 |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$600.00 |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$600.00 |
| D5221 | Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) | \$350.00 |
| D5222 | Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) | \$350.00 |
| D5223 | Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$600.00 |
| D5224 | Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$600.00 |
| D5225 | Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery | \$600.00 |
| D5226 | Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) | \$600.00 |

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| D5410 | Adjust complete denture - maxillary | No Cost |
| D5411 | Adjust complete denture - mandibular | No Cost |
| D5421 | Adjust partial denture - maxillary | No Cost |
| D5422 | Adjust partial denture - mandibular | No Cost |
| D5511 | Repair broken complete denture base, mandibular | \$100.00 |
| D5512 | Repair broken complete denture base, maxillary | \$100.00 |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) | \$80.00 |
| D5611 | Repair resin partial denture base, mandibular | \$120.00 |
| D5612 | Repair resin partial denture base, maxillary | \$120.00 |
| D5621 | Repair cast partial framework, mandibular | \$140.00 |
| D5622 | Repair cast partial framework, maxillary | \$140.00 |
| D5630 | Repair or replace broken retentive/clasping materials - per tooth | \$140.00 |
| D5640 | Replace broken teeth - per tooth | \$100.00 |
| D5650 | Add tooth to existing partial denture | \$100.00 |
| D5660 | Add clasp to existing partial denture - per tooth | \$120.00 |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | \$300.00 |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | \$300.00 |
| D5710 | Rebase complete maxillary denture | \$200.00 |
| D5711 | Rebase complete mandibular denture | \$200.00 |
| D5720 | Rebase maxillary partial denture | \$200.00 |
| D5721 | Rebase mandibular partial denture | \$200.00 |
| D5730 | Reline complete maxillary denture (chairside) | \$100.00 |
| D5731 | Reline complete mandibular denture (chairside) | \$100.00 |
| D5740 | Reline maxillary partial denture (chairside) | \$100.00 |
| D5741 | Reline mandibular partial denture (chairside) | \$100.00 |
| D5750 | Reline complete maxillary denture (laboratory) | \$200.00 |
| D5751 | Reline complete mandibular denture (laboratory) | \$200.00 |
| D5760 | Reline maxillary partial denture (laboratory) | \$200.00 |
| D5761 | Reline mandibular partial denture (laboratory) | \$200.00 |
| D5820 | Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - <i>limited to 1 in any 12 consecutive months</i> | \$300.00 |

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| D5821 | Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - <i>limited to 1 in any 12 consecutive months</i> | \$300.00 |
| D5850 | Tissue conditioning, maxillary | \$50.00 |
| D5851 | Tissue conditioning, mandibular | \$50.00 |
| D5863 | Overdenture - complete maxillary | \$450.00 |
| D5864 | Overdenture - partial maxillary | \$450.00 |

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES

All services associated with implants are listed at the actual member co-payment amount. No additional fee is allowable for porcelain, noble metal, high noble metal or titanium for procedures associated with implants.

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| D6010 | Surgical placement of implant body: endosteal implant | \$1,023.00 |
| D6011 | Second stage implant surgery | \$247.00 |
| D6012 | Surgical placement of interim implant body | \$726.00 |
| D6013 | Surgical placement of mini implant | \$665.00 |
| D6040 | Surgical placement: eposteal implant | \$2,160.00 |
| D6050 | Surgical placement: transosteal implant | \$2,051.00 |
| D6055 | Connecting bar - implant supported or abutment supported | \$250.00 |
| D6056 | Prefabricated abutment - includes modification and placement | \$418.00 |
| D6057 | Custom abutment | \$486.00 |
| D6058 | Abutment supported porcelain/ceramic crown | \$1,110.00 |
| D6059 | Abutment supported porcelain fused to metal crown (high noble metal) | \$1,096.00 |
| D6060 | Abutment supported porcelain fused to metal crown (predominantly base metal) | \$350.00 |
| D6061 | Abutment supported porcelain fused to metal crown (noble metal) | \$1,056.00 |
| D6062 | Abutment supported cast metal crown (high noble metal) | \$1,003.00 |
| D6063 | Abutment supported cast metal crown (predominantly base metal) | \$861.00 |
| D6064 | Abutment supported cast metal crown (noble metal) | \$912.00 |
| D6065 | Implant supported porcelain/ceramic crown | \$1,040.00 |
| D6066 | Implant supported crown - porcelain fused to high noble alloys | \$1,013.00 |

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| D6067 | Implant supported crown - high noble alloys | \$984.00 |
| D6068 | Abutment supported retainer for porcelain/ceramic FPD | \$1,110.00 |
| D6069 | Abutment supported retainer for porcelain fused to metal FPD (high noble metal) | \$1,096.00 |
| D6070 | Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) | \$1,035.00 |
| D6071 | Abutment supported retainer for porcelain fused to metal FPD (noble metal) | \$1,056.00 |
| D6072 | Abutment supported retainer for cast metal FPD (high noble metal) | \$1,028.00 |
| D6073 | Abutment supported retainer for cast metal FPD (predominantly base metal) | \$930.00 |
| D6074 | Abutment supported retainer for cast metal FPD (noble metal) | \$1,005.00 |
| D6075 | Implant supported retainer for ceramic FPD | \$1,092.00 |
| D6076 | Implant supported retainer for FPD - porcelain fused to high noble alloys | \$1,064.00 |
| D6077 | Implant supported retainer for metal FPD - high noble alloys | \$984.00 |
| D6082 | Implant supported crown - porcelain fused to predominantly base alloys | \$350.00 |
| D6090 | Repair implant prosthesis | \$127.00 |
| D6091 | Replacement of replaceable part | \$136.00 |
| D6092 | Re-cement or re-bond implant/abutment supported crown | \$45.00 |
| D6093 | Re-cement or re-bond implant/abutment supported fixed partial denture | \$65.00 |
| D6094 | Abutment supported crown - titanium and titanium alloys | \$670.00 |
| D6096 | Remove broken implant retaining screw | \$45.00 |
| D6101 | Debridement of a peri-implant defect | \$263.00 |
| D6102 | Debride/osseous contour of peri-implant defect | \$47.00 |
| D6103 | Bone graft for repair of peri-implant defect | \$263.00 |
| D6194 | Abutment supported retainer crown, FPD - titanium and titanium alloys | \$400.00 |
| D6197 | Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant | \$60.00 |

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

- Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #3 for additional information.

- Base metal is the benefit. If a crown, pontic, inlay, onlay or indirectly fabricated post and core is made of noble or high noble metal, an additional fee up to \$250.00 per tooth will be charged for the upgrade. This charge also applies to a titanium crown.

- Porcelain and other tooth-colored materials (i.e. resin) on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$250.00.

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| D6210 | Pontic - cast high noble metal | \$400.00 |
| D6211 | Pontic - cast predominantly base metal | \$400.00 |
| D6212 | Pontic - cast noble metal | \$400.00 |
| D6240 | Pontic - porcelain fused to high noble metal | \$400.00 |
| D6241 | Pontic - porcelain fused to predominantly base metal | \$400.00 |
| D6242 | Pontic - porcelain fused to noble metal | \$400.00 |
| D6243 | Pontic - porcelain fused to titanium and titanium alloys | \$400.00 |
| D6245 | Pontic - porcelain/ceramic | \$400.00 |
| D6250 | Pontic - resin with high noble metal | \$200.00 |
| D6251 | Pontic - resin with predominantly base metal | \$200.00 |
| D6252 | Pontic - resin with noble metal | \$200.00 |
| D6600 | Retainer inlay - porcelain/ceramic, two surfaces | \$400.00 |
| D6601 | Retainer inlay - porcelain/ceramic, three or more surfaces | \$400.00 |
| D6602 | Retainer inlay - cast high noble metal, two surfaces | \$375.00 |
| D6603 | Retainer inlay - cast high noble metal, three or more surfaces | \$375.00 |
| D6604 | Retainer inlay - cast predominantly base metal, two surfaces | \$350.00 |
| D6605 | Retainer inlay - cast predominantly base metal, three or more surfaces | \$350.00 |
| D6606 | Retainer inlay - cast noble metal, two surfaces | \$360.00 |
| D6607 | Retainer inlay - cast noble metal, three or more surfaces | \$360.00 |
| D6608 | Retainer onlay - porcelain/ceramic, two surfaces | \$400.00 |

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| D6609 | Retainer onlay - porcelain/ceramic, three or more surfaces | \$400.00 |
| D6610 | Retainer onlay - cast high noble metal, two surfaces | \$375.00 |
| D6611 | Retainer onlay - cast high noble metal, three or more surfaces | \$375.00 |
| D6612 | Retainer onlay - cast predominantly base metal, two surfaces | \$350.00 |
| D6613 | Retainer onlay - cast predominantly base metal, three or more surfaces | \$350.00 |
| D6614 | Retainer onlay - cast noble metal, two surfaces | \$360.00 |
| D6615 | Retainer onlay - cast noble metal, three or more surfaces | \$360.00 |
| D6720 | Retainer crown - resin with high noble metal | \$200.00 |
| D6721 | Retainer crown - resin with predominantly base metal | \$200.00 |
| D6722 | Retainer crown - resin with noble metal | \$200.00 |
| D6740 | Retainer crown - porcelain/ceramic | \$400.00 |
| D6750 | Retainer crown - porcelain fused to high noble metal | \$400.00 |
| D6751 | Retainer crown - porcelain fused to predominantly base metal | \$400.00 |
| D6752 | Retainer crown - porcelain fused to noble metal | \$400.00 |
| D6780 | Retainer crown - 3/4 cast high noble metal | \$400.00 |
| D6781 | Retainer crown - 3/4 cast predominantly base metal | \$400.00 |
| D6782 | Retainer crown - 3/4 cast noble metal | \$400.00 |
| D6790 | Retainer crown - full cast high noble metal | \$400.00 |
| D6791 | Retainer crown - full cast predominantly base metal | \$400.00 |
| D6792 | Retainer crown - full cast noble metal | \$400.00 |
| D6930 | Re-cement or re-bond fixed partial denture | \$60.00 |
| D6940 | Stress breaker | \$25.00 |
| D6980 | Fixed partial denture repair necessitated by restorative material failure | \$25.00 |
| D6999 | Unspecified fixed prosthodontic procedure, by report | No Cost |

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

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| D7111 | Extraction, coronal remnants - primary tooth | No Cost |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | \$40.00 |

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| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | \$100.00 |
| D7220 | Removal of impacted tooth - soft tissue | \$210.00 |
| D7230 | Removal of impacted tooth - partially bony | \$290.00 |
| D7240 | Removal of impacted tooth - completely bony | \$360.00 |
| D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications | \$350.00 |
| D7250 | Removal of residual tooth roots (cutting procedure) | \$210.00 |
| D7251 | Coronectomy - intentional partial tooth removal, impacted teeth only | \$350.00 |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | \$340.00 |
| D7280 | Exposure of an unerupted tooth | \$210.00 |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption | \$290.00 |
| D7283 | Placement of device to facilitate eruption of impacted tooth | \$250.00 |
| D7286 | Incisional biopsy of oral tissue - soft - does not include pathology laboratory procedures | \$260.00 |
| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | \$150.00 |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | \$150.00 |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | \$170.00 |
| D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | \$170.00 |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm | \$380.00 |
| D7451 | Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm | \$380.00 |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | \$330.00 |
| D7472 | Removal of torus palatinus | \$330.00 |
| D7473 | Removal of torus mandibularis | \$330.00 |
| D7509 | Marsupialization of odontogenic cyst | \$380.00 |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | \$40.00 |
| D7960 | Frenulectomy - also known as Frenectomy or Frenotomy - separate procedure not incidental to another procedure | \$180.00 |

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| D7970 | Excision of hyperplastic tissue - per arch | \$170.00 |
| D7971 | <i>Excision of pericoronal gingiva</i> | \$120.00 |
| D8000-D8999 | XI. ORTHODONTICS - Not Covered | |
| D9000-D9999 | XII. ADJUNCTIVE GENERAL | |
| D9110 | <i>Palliative treatment of dental pain - per visit</i> | \$20.00 |
| D9211 | Regional block anesthesia | No Cost |
| D9212 | Trigeminal division block anesthesia | No Cost |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | No Cost |
| D9219 | Evaluation for moderate sedation, deep sedation or general anesthesia - <i>1 per 6 month period</i> | No Cost |
| D9222 | Deep sedation/general anesthesia - first 15 minutes | \$75.00 |
| D9223 | Deep sedation/general anesthesia - each subsequent 15 minute increment | \$75.00 |
| D9239 | Intravenous moderate (conscious) sedation/analgesia - first 15 minutes | \$75.00 |
| D9243 | Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment | \$75.00 |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | \$40.00 |
| D9311 | Consultation with a medical health care professional | No Cost |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | No Cost |
| D9440 | Office visit - after regularly scheduled hours | \$50.00 |
| D9450 | Case presentation, subsequent to detailed and extensive treatment planning | No Cost |
| D9932 | Cleaning and inspection of removable complete denture, maxillary - <i>1 per 6 month period</i> | No Cost |
| D9933 | Cleaning and inspection of removable complete denture, mandibular - <i>1 per 6 month period</i> | No Cost |
| D9934 | Cleaning and inspection of removable partial denture, maxillary - <i>1 per 6 month period</i> | No Cost |
| D9935 | Cleaning and inspection of removable partial denture, mandibular - <i>1 per 6 month period</i> | No Cost |
| D9943 | Occlusal guard adjustment | \$10.00 |
| D9944 | Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i> | \$300.00 |

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| D9945 | Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i> | \$300.00 |
| D9946 | Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i> | \$300.00 |
| D9950 | Occlusion analysis - mounted case | \$160.00 |
| D9951 | Occlusal adjustment - limited - for natural teeth only | \$70.00 |
| D9952 | Occlusal adjustment - complete - for permanent dentition | \$120.00 |
| D9975 | External bleaching for home application, per arch; includes materials and fabrication of custom trays | \$170.00 |
| D9986 | Missed appointment - <i>without 24 hour notice</i> | No Cost |
| D9987 | Canceled appointment - without 24 hour notice | No Cost |
| D9991 | Dental case management - addressing appointment compliance barriers | No Cost |
| D9992 | Dental case management - care coordination | No Cost |
| D9995 | Teledentistry - synchronous; real-time encounter | No Cost |
| D9996 | Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review | No Cost |

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by an oral surgeon for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241);
3. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Contact the Customer Service department at 800-422-4234 if you have questions regarding the additional fee or name brand services.

Exclusions of Benefits

1. Any procedure that is not specifically listed under Schedule A, Description of Benefits and Copayments.
2. Any procedure that in the professional opinion of the Contract Dentist:
 - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
 - b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant, unless listed as a covered benefit.
8. Consultations for non-covered benefits.
9. Dental services received from any dental facility other than the assigned Contract Dentist or a preauthorized dental specialist except for Emergency Services as described in the Contract and/or Evidence of Coverage.
10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, Home Health services or other similar care facility.
11. Ambulance services.
12. Durable Medical Equipment.
13. Mental health services.
14. Chemical Dependency services.
15. Prescription drugs.
16. General anesthesia and/or intravenous sedation/analgesia.
17. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DHMO Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Note

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